Personal Care Services

Definition: Personal Care Services are defined as assistance, either hands-on (actually performing a personal care task for a person) or cueing so that the person performs the task by him/herself, in the performance of Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs). ADLs include eating, bathing, dressing, toileting, transferring, personal hygiene, and maintaining continence. IADLs capture more complex life activities and include light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, to include informing a client that it is time to take medication as prescribed by his/her physician or handing a client a medication container, and money management to consist of delivery of payment to a designated recipient on behalf of the client. Personal Care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Authorizations to providers will be made at two different payment levels. The higher level will be called Personal Care II and will be used when the majority of care is related to activities of daily living (e.g. hands-on care to include bathing, dressing, toileting, etc.). This service may also include monitoring temperature, checking pulse rate, observing respiratory rate, and checking blood pressure. The lower level, Personal Care I, will be authorized when all of the needed care is for instrumental activities of daily living (e.g. hands off tasks such as laundry, meal preparation, shopping, etc.). Both services allow the provider to accompany the individual on visits in the community when the visits are related to the needs of the individual, specified in the plan of care, and related to needs for food, personal hygiene, household supplies, pharmacy or durable medical equipment. You have the responsibility to identify the necessity of the trip, document the plan of care, authorize this component of the service, and monitor the provision of the services.

Note: Personal Care Services cannot be rendered in a school setting.

Note: **Personal Care Services may only be provided in lieu of In-Home Supports**

Note: In-Home Support should also be discussed as an option to Personal Care when identified needs can be met by either service.

Relatives/family members of a waiver recipient may be paid to provide Personal Care Services when the relative is not a legally responsible relative/family member and he/she meets all South Carolina Medicaid provider qualifications. Please see **Department Directive 736-01** entitled **"Relatives/Family Members Serving As Paid Caregivers of Certain Medicaid Waiver Services"** for specific information.

The following relatives/family members will not be paid for providing Personal Care Services:

- The spouse of the Waiver recipient;
- A parent of a minor Waiver recipient;
- A legally responsible foster parent of a minor Waiver recipient;
- A legally responsible guardian of a minor Waiver recipient;
- A court appointed guardian of an adult Waiver recipient.
- Step-parent of a minor Medicaid recipient.

The following relatives/family members may be paid for providing Personal Care Services when all South Carolina Medicaid provider qualifications are met.

- A parent of an **adult** Medicaid recipient
- A non-legally responsible relative/family member of a minor or adult Medicaid recipient

Relatives/family members who are a primary caregiver of the recipient will not be paid for **all** of the care they provide. The amount to be paid will be based on the recipient's needs as determined by SCDDSN. SCDDSN relies on the informal supports provided by family members to individuals. Only the needs of the recipient will

be considered. Services of specific benefit to the recipient will be considered for authorization. Services that benefit the entire household will not be considered.

A by-product of the provision of Personal Care services by someone outside of the recipient's home is that it affords the primary caregiver some relief from the responsibilities of care giving. **Family members who are a primary caregiver and who opt to be paid for a portion of the care/service they provide, will not also be authorized to receive additional respite services.**

Payment to non-legally responsible family members (brother, sister, step parent, grand parent etc.) living in the same household as the Waiver recipient is allowed.

Personal Care Companies or agencies, including DSN Boards, are under no obligation to hire relatives/family members to provide services.

When a relative/family member wishes to be paid for providing Personal Care I or Personal Care II Services, you should refer the relative/family member to:

- any company or agency directly enrolled as a provider with the South Carolina Department of Health and Human Services

Note: Aides who provide Personal Care II services must do so under the supervision of a nurse.

Note: Service Coordinators are expected to monitor the services with the same frequency as would be required if provided by a non-relative caregiver.

Providers: Personal Care Services are to be provided to recipients by an agency enrolled with the Department of Health and Human Services. Agencies enrolled with the Department of Health and Human Services must adhere to the requirements noted in the Scopes of Services for Personal Care Services (I and II) for the Community Supports Waiver (attached). The Scopes of Service specify the minimum qualifications for a Personal Care Aide I and II.

Arranging for the Services: In order to determine the amount of Personal Care Services needed, you must complete the **Personal Care Needs Assessment (Community Supports Form PC-34)** with the consumer/legal guardian. The need for the service must be clearly outlined in the recipient's plan/Waiver Services Summary Page to include the amount, frequency and duration.

The recipient/family should be given a listing of available providers from which to choose. **The offering of this provider choice must be documented.**

When entering the budget request for Personal Care Services (I or II) on the Waiver Tracking system (PC I – S29 or PC II – S10), please note that for individuals needing 25 hours/100 units or less per week of Personal Care, services may be approved at the local level and authorized. For anyone requiring more than 25 hours/100 units per week, you must submit the **Personal Care Needs Assessment (Community Supports Form PC-34)** to their respective District Waiver Coordinator for review and approval. See Chapter 6 for contact information for your District Waiver Coordinator.

For children under the age of 21, the State Plan covers ALL Personal Care Services. If a Medicaid recipient under the age of 21 is also enrolled in the Community Supports Waiver, you assess the need and authorize those State Plan Services. After determining and documenting the need, use the Community Supports Form PC-3 to authorize the service. Units of service are not entered on the participants Community Supports Waiver budget, however, the entire amount of units to be provided is included on the Authorization for Services Form (Community Supports Form PC-3) and indicated in the participants plan. Once the recipient reaches the age of 21, units must then be added to the Community Supports Waiver budget.

Agency Services: Once the service is approved, an authorization **(Community Supports Form PC-3)** is completed and forwarded to the chosen agency. If the consumer is under the age of twenty-one (21), a Physician's Order must accompany the referral and be include in the consumer's file. **Community Supports Form PC-15** may be used for this purpose. On the **Community Supports Form PC-3** you must indicate either Personal Care Services I (PC I) or Personal Care Services II (PC II) and include the personal care activities that are requested. These activities must correspond to the assessment (see notes on the assessment).

Upon receipt of the **Community Supports Form PC-3**, the agency is authorized to provide the services. This authorization remains in effect until a new/revised **Community Supports PC-3** is sent or until services are terminated (see Chapter 8).

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service (refer to Chapter 9 "Monitorship of Community Supports Waiver Services"). Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following schedule should be followed when monitoring Personal Care Services (I and II).

- Must complete on-site monitorship during the first month while the service is being provided unless a Supervisor makes an exception. An exception is defined in the following circumstances:
    - the service is **only provided** in the early morning hours (prior to 7:00 a.m.)
    - the service is **only provided** in late evening hours (after 9:00 p.m.)
    - The exception and approval by the Supervisor must be documented. **NO** other exceptions will be allowed.
- At least once during the second month of service
- At least quarterly thereafter
- Start over with each new provider
- Yearly on-site monitorship required.

In addition, you should review the daily logs completed by the aides during an on-site visit. Monitorship of the individual's health status should always be completed as a part of Personal Care monitorship.

Some items to consider during monitorship include:

- Is the individual receiving Personal Care services as authorized?
- Does the PCA show up on time and stay the scheduled amount of time?
- If the PCA does not show up for a scheduled visit, who is providing back-up services?
- What kinds of tasks is the PCA performing for the individual? Does the service need to continue at the level that it has been authorized?
- Has the individual's health status changed since your last monitorship? If so, is the current level of Personal Care appropriate?
- Is the individual satisfied with the provider of services? Does the provider show the individual courtesy and respect when providing the individual's care?
- Who is providing supervision of the PCA? How often is on-site supervision taking place?

Reduction, Suspension, or Termination of Services: If services need to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian. Include the details regarding the change(s) in service and the Reconsideration and Appeal Information. You must wait ten (10) calendar days before proceeding with the reduction, suspension or termination of the service. See **Chapter 8** for specific details and procedures regarding written notification and the appeals process.

Community Supports Waiver
Personal Care Needs Assessment

CSW Waiver Recipient:_____

Social Security Number:_____

Age:_____**Service Requested** ☐ PC I ☐ PC II ☐ Attendant Care

I. Personal Care Needs

Bath: Bed ☐ Shower/Tub ☐	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Shaving:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Oral Hygiene:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required _____
Skin Care:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required _____
Dressing and Grooming:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Incontinence Care:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Toileting:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Positioning and Turning in Bed:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Medication Monitoring:	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Other Medical Monitoring:			
_____	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
_____	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Exercise	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Ambulation/Escort Services:	Distance _____		Frequency and Time Required_____
Transfers:			
Hoyer ☐ Sliding Board ☐ Lift System ☐ Other _____			
	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
Other Personal Care Needs:			
_____	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____
_____	Partial Assist ☐	Total Assist ☐	Frequency and Time Required_____

II. Meal and Dining Needs

Preparation and Set-Up	Partial Assist ☐	Total Assist ☐	
Frequency: and Time Required	Breakfast_____	Lunch _____	Dinner_____
Feeding	Partial Assist ☐	Total Assist ☐	
Frequency: and Time Required	Breakfast_____	Lunch _____	Dinner_____
Clean Up	Partial Assist ☐	Total Assist ☐	
Frequency: and Time Required	Breakfast_____	Lunch _____	Dinner_____

III. General Housekeeping Needs (not appropriate for children under the age of twelve)

Vacuuming Recipient's Room/Area: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

Sweeping Recipient' Room/Area: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

Dusting Recipient's Room/Area: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

Mopping Recipient's Room/Area: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

Cleaning Recipient's Bathroom: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

Cleaning Recipient's Bedroom: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

Recipient's Laundry: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

IV. Other Needs:

Shopping Assistance*: Errands Daily ☐ Weekly ☐ Monthly ☐ Time Required _____

Escort Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

***not appropriate for recipient's under age eighteen**

Assistance with Communication: Daily ☐ Weekly ☐ Monthly ☐ Time Required_____

V. Requested Schedule for Personal Care Services:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Total Units Needed Daily:_____

Total Units Needed Weekly:_____

Total Units of Personal Care I/Personal Care II recommended_____per day/week/month

(circle one) (circle one)

Include justification for or against recommended amount of Personal Care I or II_____

_____

_____

_____

_____ _____

Signature of Person Completing Assessment **Title**

_____

Date

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORTS WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

_____
Phone Number

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

Social Security # /___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # **C S** ___/___/___/___/___/

Personal Care Services
_____ **Personal Care I (PC I) S5130**
_____ **Personal Care II (PC II) T1019**

Number of Units Per Week to be Provided:_____ (one unit = 15 minutes)
Start Date:_____

Service Tasks Requested:

☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
☐ Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
☐ Assistance with exercise, ambulation, positioning, etc.
☐ Transportation and/or escort services

Please note: Physician's order must be attached for individuals under age 21. Community Supports Form PC-15 may be used.

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

_____

_____

_____

Signature of Person Authorizing Services Date

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

COMMUNITY SUPPORTS WAIVER

PHYSICIAN'S ORDER FOR PERSONAL CARE SERVICES

Participant's Name: _____

Date of Birth: _____

SSN: _____

I hereby order Personal Care Services to be rendered to the above named participant.

_____
Physician's Name

_____
Address

_____
Phone #

_____ _____
Physician's Signature